Patient #_____

PATIENT HEALTH HISTORY

Name: _____ Birthdate: _____ Today's Date: _____

Please help us by taking the time to complete the following information on this form as accurately as possible. The information obtained on this form will remain confidential and will become part of your patient record. Thank you for your cooperation.

CHIEF COMPLAINT: (Please check the symptoms that you currently have or have had in the past)

__ Weight Loss/Poor Appetite	__ Rectal Bleeding/Blood in Stool	__ Heart Burn
__ Fever/Chills	__ Change in Bowel Habits	__ Hoarseness
__ Abdominal Pain	__ Nausea/Vomiting	__ Swallowing Difficulties
__ Constipation	__ Chest Pain	__ Pain with Swallowing
__ Diarrhea	__ Cough	__ Anemia

__ Others not listed _____
_____

Personal Medical History

Surgery:	**Year:**	**Details/Complications:**
__ Appendectomy	_____	_____
__ Gallbladder	_____	_____
__ Hernia Repair	_____	_____
__ Hysterectomy	_____	_____
__ Intestinal/Abdominal	_____	_____
__ Stomach/Duodenal Ulcer	_____	_____
__ Surgery Not Listed Above	_____	_____
	_____	_____
	_____	_____

Hospitalizations other than surgery:	**Date/Hospital**
_____	_____
_____	_____
_____	_____
_____	_____

Previous Endoscopies (Colonoscopy, EGD, ERCP)	**Date**
_____	_____
_____	_____
_____	_____

Current Medical Problems:

__ Arthritis	__ Asthma	__ Anxiety/Depression
__ Cancer, Type: _____	__ Crohn's/Colitis	__ Diabetes
__ Defibrillator/Pacemaker	__ Epilepsy/Seizure	__ Gallstones
__ Heart Problems: _____	__ Hepatitis	__ Lung Disease
__ High Blood Pressure	__ Kidney Disease	__ Osteoporosis
__ Stent Placement: _____	__ Sleep Apnea	__ Stroke
__ Thyroid Problems	__ Prostate	__ History of H. pylori

__ Cervical Pap Date: _____ Results: _____
__ Other: _____

Patient #_____

Name: _____ Birthdate: _____ Today's Date: _____

Medications: (Include prescriptions, over-the-counter, and herbals products)

Name	**Dose/Frequency**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies to Medications: (Include latex/tape, iodine, and/or severe adverse)

Medication	Reaction
_____	
_____	
_____	
_____	

Are you allergic to Latex?
__ Yes __ No

Family History: (Please include **age** of diagnosis for family member)

	Father	Mother	Brother/Sister	Other
Generations				
Colon Cancer	_____	_____	_____	_____
Colon or Rectal Polyps	_____	_____	_____	_____
Stomach/Small Bowel Cancer	_____	_____	_____	_____
Pancreatic Cancer	_____	_____	_____	_____
Uterine/Ovarian Cancer	_____	_____	_____	_____
Renal/Ureteral Cancer	_____	_____	_____	_____
Breast Cancer	_____	_____	_____	_____
Liver Disease	_____	_____	_____	_____
Gallbladder Disease	_____	_____	_____	_____
Colitis/Crohn's Disease	_____	_____	_____	_____
Other	_____	_____	_____	_____

Social History: (Past or Current)

Alcohol __ No __ Yes __ Quit/When _____ Drinks per Day ___ # Years _____
Tobacco __ No __ Yes __ Quit/When _____ Packs per Day ____ # Years _____
Recreational Drug Use __ No __ Yes __ Quit/When _____ Used Needles: __Yes __No
Drug Used: _____
Coffee/Caffeine Use __ No __ Yes __ Quit/When____ Amount per Day _____
Blood Transfusions __ No __ Yes When? _____
Tattoos/Piercings __ No __ Yes

Do you take **antibiotics** prior to dental work on a regular basis? __Yes __ No Why?_____

Thank you for your time and cooperation.